

# group practice journal

PUBLICATION OF THE AMERICAN MEDICAL GROUP ASSOCIATION®

## **Internal Benchmarking**

*How to Construct "Apples to Apples" Productivity Comparisons*



# Level the Playing Field in Healthcare Reimbursement

BY MARION LIVINGSTONE



**M**ounting financial pressures are nothing new to health-care organizations. But as the landscape changes, these shifting pressures tend to create new opportunities.

In all regions of the United States, average reimbursement from commercial payers and Medicare fell in 2006, with payment levels averaging significantly below those reported in 2002 and 2004.<sup>1</sup> The margins for medical group practices have been particularly slim in recent years.

In addition to cost-cutting measures, some practices are attempting to improve their financial situation by seeking to better understand the complexity and

mystery of payers' reimbursement methodologies.

---

## **MEDICAL COLLEGE OF WISCONSIN TAKES BACK REVENUES THROUGH AUTOMATED CONTRACT MANAGEMENT.**

---

Until recently, even the most efficient medical practices had no realistic way to ensure that reimbursements followed contractual policies, much less to determine with any certainty what those amounts should have been. And payers can make claims adjudication mistakes for a variety of reasons. Mergers and acquisitions have exacerbated their IT challenges. Incorrect or outdated fee schedules

may be loaded. The contracts themselves can be difficult to administer.

Though managed care is not getting any more comprehensible or accessible, information technology is maturing rapidly. Many provider organizations are starting to apply IT to the problem.

### **Learning about the Challenge**

Like many medical groups, the Medical College of Wisconsin (MCW) had suspected for quite a while that our medical claims were not being paid per our contractual terms. And, like most medical practices, we did not have a practical method for determining accurate reimbursement. In 2000, management at MCW began investigating possible ways to tackle this challenge.

Based in Milwaukee, MCW is a private, academic institution with more than 1,000 faculty physicians and allied health providers who provide adult and pediatric care to more than 260,000 patients—representing more than a million patient visits annually. Given our size, we realized that even with a small percentage of underpayments, the business case to act would still be compelling.

Our first approach was to build an in-house solution for tracking payer contract compliance. The program we developed relied on fee schedules loaded by our staff. It did help us flag some potential payment variances, but it did not offer the level of functionality we needed to make the impact on financial performance MCW was looking for.

The in-house solution lacked the sophistication required to value a claim based on the numerous variables and payment policies stipulated in a payer contract. The system was missing the rules-based logic to review things like modifiers or specialty-specific rates. Overall, the process was cumbersome and often caused staff members to research more claims than necessary.

In 2003, MCW began looking for a better way. We needed a new solution that would further automate the process of monitoring contract performance and also support an efficient method for filing appeals and tracking our success. Based on our past experience, we realized we needed the expertise of a technology partner with specialized experience.

In terms of product and service capabilities, we realized that our contract management and claims auditing solution would need to consider every variable that affects payment. In addition to fee schedule data and even contract-specific terms, it should calculate appropriateness based on carve-outs, bundling edits, modifiers, geographic edits, global fee periods, place of service edits, and dozens of other factors.

One of the more important qualifications we sought in a vendor was experience working with physician group practices in general and, more specifically, success serving other academic medical groups. We also ranked intuitive, easy-to-use reporting tools high on our list. We wanted a product that was comprehensive but would not create a lot of unnecessary work for any of our staff members.

### **Taking a Different Approach**

Our search led us to Medical Present Value (MPV), an Austin-based provider of payer compliance services and technology. We worked with MPV to implement the Web-

based MPV Phynance™ application to track payer contract compliance at the line-item level and explain in detail why, using contractual terms, a payment variance was detected. The system is designed specifically to optimize reimbursement by defining and modeling payers' reimbursement rules and automatically verifying that payments follow the terms of the contract.

With this tool in place, we looked forward to the ability to uncover and appeal even the small underpayments, which if high in volume can add up substantially. As a workflow tool, the system would also support our billing staff through the process of appealing these improper reimbursements, whether on a claim-by-claim or bulk appeal basis.

We could see that MPV had a unique combination of both information technology and professional services that could get a lot accomplished in a reasonable timeframe. We liked the idea of a potential "quick win" with a relatively rapid deployment. These services would quickly get us up to speed, allowing our billing and contracting staff to get to work determining accurate payments for medical claims based on this complex mix of payment variables, fee schedules, and policies. They would also help our staff keep on top of constantly changing payment rules so that claims pricing was as up-to-date as possible.

Initially, we had planned on investing in a traditional "in-house," server-based application. But we were drawn to the advantage of avoiding large capital outlays for hardware, software, and training. With a Web-based application, our staff can access the system with a simple Internet connection. The browser-based interface minimizes the time and expense associated with training as well as implementation.

Of course, technology and even contract expertise can only take an

organization so far. MPV provides a tool with which we can identify payment variances and utilize reimbursement data for areas of improvement to our business processes. But the challenge ultimately falls on our billing staff to leverage the information, base appeals on it, and recover revenue.

Fortunately, MPV had experience and a strong working knowledge of contract provisions, reimbursement, coding rules, and appeals procedures. We worked as a team to interpret contract language while managing the dynamics specific to each payer relationship.

### **Appealing Outcome**

Automated contract management made our billing and contracting staff much more productive. First, we know what reimbursements should be for each claim. Second, with the majority of payments flowing through the system, our staff members can monitor many more payments than they could in the past.

---

### **MUCH OF THE VALUE FROM THIS NEW PROCESS COMES FROM MONITORING AND MANAGING APPEALS.**

---

Our ability to value medical claims according to contractual terms improved significantly. After implementation, our primary focus remained on identifying these contractual underpayments and tracking the resulting appeals. We also found our new reporting capabilities were valuable in that they helped our staff monitor individual contract performance.

The most important result for financial technologies is found in the bottom line. Using MPV, we have indeed been able to enhance the value of our payer contracts. From July 2005 to June 2006, we recovered \$950,000.

Much of the value from this new

process comes from monitoring and managing appeals. We can now investigate and see monthly trends. We can review specific payers and learn what claims are under appeal and what has been recovered.

All of this accelerates the appeals process, too, and that improves our cash flow. For example, appeals are now supported by specific data that fully explains why an underpayment exists and why it is a variance. When we tell our payers we have been underpaid, we are confident in our data and they do not worry that we are wasting their time. So, while our staff is more productive, they're also building stronger relationships with payers.

Our contract management solution also improved our business performance when transitioning to new contracts. In the past, after we renewed a payer contract, it took eight or nine months for us to identify payment patterns and trends. Now, we have an immediate snapshot of how that contract is performing, so we can easily see when payers do not reimburse accurately. The ability to expedite and enhance this tracking process has been an added benefit of using the contract management system.

Recently, we've expanded our use of the data stored in our contract management application to assess the implications of proposed contracts. With this data, we have a better sense of how much each department could gain or lose before agreeing to new contract terms. This capability allows our group to target our negotiating strategy to those factors that affect our reimbursement the most.

With the help of automation and reimbursement expertise from domain experts, and a very committed internal staff, medical practices like ours can level the playing field in health care.

## References

1. Pamela L. Moore. 2007. The 2006 Fee Schedule Survey: Power to the Payors. *Physicians Practice*, January 2007.

*Marion Livingstone is executive director of clinical practices services at Medical College of Wisconsin in Milwaukee.*

Reprinted with permission of The American Medical Group Association®  
©Group Practice Journal May 2007